



CHILD PROTECTION SERVICES INTAKE SUMMARY

State Form 52778 (11-06) / CW 2131

DEPARTMENT OF CHILD SERVICES

In compliance with Indiana Public Law 276, Acts of 1979, IC 31-33-18, the information provided upon completion of this form will be treated as a confidential record.

* This agency is requesting the disclosure of your Social Security number in accordance with IC 4-1-8-1. Disclosure is voluntary and you will not be penalized for refusal.

Report type	Report name	Report number	Report date (month, day year)	Report time <input type="checkbox"/> AM <input type="checkbox"/> PM
-------------	-------------	---------------	-------------------------------	--

GENERAL INFORMATION

Current date (month, day, year)	Date of incident (month, day, year)	Time of incident <input type="checkbox"/> AM <input type="checkbox"/> PM	Region	County
Address of household (number and street)			Home telephone number ()	
City, state, and ZIP code			Other telephone number ()	
Report taken by		Data entered by	Name of assigned investigator	

Is child in imminent danger of serious bodily harm? ☐ Yes ☐ No

CHILD INFORMATION

RACE: AI = American Indian or Alaskan Native; A = Asian; AA = Black or African American; M = Multiracial; NH = Native Hawaiian or other Pacific Islander; W = White; and U = Unable to determine.

ROLE: V = Victim (V1, V2, V3, etc.); VP = Victim / Perpetrator; P = Perpetrator; NI = Not involved.

Name of child		Date of birth (month, day, year)		Age	Sex	Race	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No
Exigent circumstances <input type="checkbox"/> Yes <input type="checkbox"/> No	Role	ICWIS person ID number	Social security number *		School / grade		
Current Location of child (if other than own home) (number and street, city, state, and ZIP code)							
Name of child		Date of birth (month, day, year)		Age	Sex	Race	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No
Exigent circumstances <input type="checkbox"/> Yes <input type="checkbox"/> No	Role	ICWIS person ID number	Social security number *		School / grade		
Current Location of child (if other than own home) (number and street, city, state, and ZIP code)							

ALLEGATION NARRATIVE

Does person responsible for alleged abuse have access to child? ☐ Yes ☐ No

<input type="checkbox"/> Physical abuse <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Neglect	Describe what happened, when and where it occurred, who witnessed the incident, the last time the reporter saw the child, and whether or not the reporter is aware of any other incidents of CA/N.
--	--

Name of child	Alleged perpetrator	Allegation(s)
Name of child	Alleged perpetrator	Allegation(s)

LEA involvement <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe what their involvement is. Provide name of contact person, LEA case number, and telephone number, if possible.
---	---

Does allegation(s) meet statutory definition of CHINS? ☐ Yes ☐ No

Recommended response timeframe. ☐ One (1) hour ☐ 24 hours ☐ Five (5) days

Worker safety concerns

<input type="checkbox"/> None	<input type="checkbox"/> Gang involvement	<input type="checkbox"/> Violent propensities
<input type="checkbox"/> Animals	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Weapons
<input type="checkbox"/> Communicable diseases	<input type="checkbox"/> Remoteness	<input type="checkbox"/> Other _____
<input type="checkbox"/> Drug use	<input type="checkbox"/> Suspected drug manufacturing / Meth lab	

Directions to home

Type of housing	<input type="checkbox"/> Single family home	<input type="checkbox"/> Trailer	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Apartment	<input type="checkbox"/> Multiple family dwelling	

Report type	Report name	Report number	Report date (month, day year)	Report time	<input type="checkbox"/> AM <input type="checkbox"/> PM			
INVOLVED ADULTS INFORMATION (parent / guardian / custodian / alleged perpetrator)								
RACE: AI = American Indian or Alaskan Native; A = Asian; AA = Black or African American; M = Multiracial; NH = Native Hawaiian or other Pacific Islander; W = White; and U = Unable to determine.								
Name		ICWIS person ID number	Date of birth (month, day, year)	Age	Sex	Race	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address (number and street)			Home telephone number ()		Social security number *			
City, state, and ZIP code			Other telephone number ()		Name of child / relationship			
Alleged perpetrator <input type="checkbox"/> Yes <input type="checkbox"/> No	Household member <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments (include information such as whether the alleged perpetrator is incarcerated, aware of report, etc.)						
Name		ICWIS person ID number	Date of birth (month, day, year)	Age	Sex	Race	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address (number and street)			Home telephone number ()		Social security number *			
City, state, and ZIP code			Other telephone number ()		Name of child / relationship			
Alleged perpetrator <input type="checkbox"/> Yes <input type="checkbox"/> No	Household member <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments (include information such as whether the alleged perpetrator is incarcerated, aware of report, etc.)						
OTHERS IN HOUSEHOLD NOT ALREADY IDENTIFIED								
Name		ICWIS person ID number	Date of birth (month, day, year)	Age	Sex	Race	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social security number *		Name of child / relationship		Comments				
REPORTER								
Name (if applicable, include title and name of agency)			Report date (month, day year)		Report time <input type="checkbox"/> AM <input type="checkbox"/> PM			
Address (number and street)				Home telephone number ()				
City, state, and ZIP code				Other telephone number ()				
<input type="checkbox"/> Anonymous	<input type="checkbox"/> Community mental health	<input type="checkbox"/> Dentist	<input type="checkbox"/> Hospital / clinic					
<input type="checkbox"/> LEA	<input type="checkbox"/> Licensed psychologist	<input type="checkbox"/> Managed care provider	<input type="checkbox"/> Neighbor					
<input type="checkbox"/> Relative	<input type="checkbox"/> Referring physician	<input type="checkbox"/> School	<input type="checkbox"/> Other _____					
Basis for report								
<input type="checkbox"/> Observed physical evidence		<input type="checkbox"/> Suspicion		<input type="checkbox"/> Told by child		<input type="checkbox"/> Told by third party		
<input type="checkbox"/> Witnessed		<input type="checkbox"/> Other _____						
Action taken by reporter								
Is reporter available for follow-up and/or further discussion? <input type="checkbox"/> Yes <input type="checkbox"/> No								
POTENTIAL COLLATERAL SOURCES								
Name				Relationship				
Address (number and street)				Home telephone number ()				
City, state, and ZIP code				Other telephone number ()				
Comments								
PREVIOUS CPS HISTORY / ADDITIONAL INFORMATION								
<input type="checkbox"/> ICES	ID number	Comments						
<input type="checkbox"/> ISETS	ID number	Comments						
<input type="checkbox"/> Other	Comments							

Report type	Report name	Report number	Report date (month, day year)	Report time <input type="checkbox"/> AM <input type="checkbox"/> PM
PREVIOUS CPS HISTORY / ADDITIONAL INFORMATION (continued)				
<input type="checkbox"/> ICWIS	SUMMARY OF PREVIOUS CPS HISTORY			
DATE OF INCIDENT	NAME OF PERSON RESPONSIBLE	TYPE OF ABUSE	NAME OF VICTIM(S)	FINDING
LANGUAGE NEEDS				
<input type="checkbox"/> Sign language <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____				
SPECIAL REPORTS				
<div> <input type="checkbox"/> Child fatality - ward of the State <input type="checkbox"/> Child near fatality <input type="checkbox"/> Institutional <input type="checkbox"/> Child fatality - not ward of the State <input type="checkbox"/> Joint investigation with LEA <input type="checkbox"/> Restricted <input type="checkbox"/> Newborn case - high risk (<i>less than 4 weeks of age</i>) <input type="checkbox"/> Intentionally false report <input type="checkbox"/> Medical neglect of handicapped child <input type="checkbox"/> Adoption case (<i>abuse / neglect in pre-adoptive home</i>) </div>				
Comments				
INTAKE DECISION (INTAKE WORKER)				
Decision				
<input type="checkbox"/> Investigate <input type="checkbox"/> Screen-out <input type="checkbox"/> Transfer <input type="checkbox"/> Link (<i>to case or another investigation</i>) <input type="checkbox"/> Information and referral				
Comments				
Signature of family case manager			Date of signature (month, day, year)	Time <input type="checkbox"/> AM <input type="checkbox"/> PM

Report type	Report name	Report number	Report date (month, day, year)	Report time <input type="checkbox"/> AM <input type="checkbox"/> PM
SUPERVISORY REVIEW OF INTAKE WORKER DECISION				
Decision <input type="checkbox"/> Investigate <input type="checkbox"/> Screen out <input type="checkbox"/> Transfer <input type="checkbox"/> Assign <input type="checkbox"/> Link (to case or another investigation) <input type="checkbox"/> Information and referral				
Suggested timeframe to investigate (supervisor can only decrease investigation time, not increase) <input type="checkbox"/> One (1) hour <input type="checkbox"/> 24 hours <input type="checkbox"/> Five (5) days <input type="checkbox"/> Supervisor override to decrease response time _____				
Reason for override				
Comments				
Signature of supervisor			Date of signature (month, day, year)	Time <input type="checkbox"/> AM <input type="checkbox"/> PM
COUNTY DIRECTOR REVIEW OF SCREEN OUT CA/N REPORTS				
<input type="checkbox"/> Agree with screen out decision <input type="checkbox"/> Disagree with screen out decision - Investigate <input type="checkbox"/> Disagree with screen out decision - Information and referral				
If decision to investigate, request timeframe <input type="checkbox"/> One (1) hour <input type="checkbox"/> 24 hours <input type="checkbox"/> Five (5) days				
Comments				
Signature of county director			Date of signature (month, day, year)	Time <input type="checkbox"/> AM <input type="checkbox"/> PM
SCREEN OUT COMMITTEE REVIEW OF SCREENED OUT CA/N REPORTS				
<input type="checkbox"/> Agree with screen out decision <input type="checkbox"/> Disagree with screen out decision - Investigate <input type="checkbox"/> Disagree with screen out decision - Information and referral				
If decision to investigate, request timeframe <input type="checkbox"/> One (1) hour <input type="checkbox"/> 24 hours <input type="checkbox"/> Five (5) days				
Comments				
Signature of committee member			Date of signature (month, day, year)	Time <input type="checkbox"/> AM <input type="checkbox"/> PM